Congress of the United States
House of Representatives
Washington, D.C. 20515

March 6, 2009

Ms. Charlene Frizzera
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Frizzera:

We are writing regarding the "Advance Notice of Methodological Changes for Calendar Year 2010 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies," published by the Centers for Medicare & Medicaid Services (CMS) on February 20, 2009.

The Advance Notice proposes a major improvement in payment accuracy for Medicare Advantage (MA) plans by specifying a method for adjusting payments to plans to account for differences in risk score coding patterns between MA and fee-for-service (FFS) Medicare. This proposal is long overdue and portends an immediate improvement in the stewardship of the Medicare program under the leadership of President Obama.

Differences in coding patterns can arise because plans are highly motivated to identify and code diseases in their populations: each new disease identified, whether it is treated or not, can increase the payment the plan receives from CMS. Physicians in FFS are not encouraged to "discover" new codes, so plan risk scores increase at a greater rate than FFS risk scores. That makes enrollees look less healthy without any actual change in health status and drives up payments to plans even beyond the 14% excess payment documented by the Medicare Payment Advisory Commission and the Congressional Budget Office.

That "upcoding" in MA has no bearing on the clinical outcomes or cost of care for Medicare beneficiaries; upcoding is merely a mechanism by which plans can manipulate the risk adjustment system to maximize payments from the government. Because such payments are not tied directly to plan benchmarks or bids, there is no assurance that they will be passed through to beneficiaries as extra benefits.

MA plans have argued that the 0.5% update estimated in the Advance Notice is insufficient and that, therefore, CMS should not adjust payments for differences in coding patterns. Those plans are paid 14% more than it would cost original Medicare to treat the same patients, or more than $1,000 per patient per year. The fact of a small — but positive —update should not bear on the decision to correct inaccuracies in the risk adjustment system.

The methodology proposed in the Advance Notice is consistent with Congressional intent as expressed in two pieces of legislation.

The Balanced Budget Act of 1997 instructed CMS to develop a risk adjustment system for Medicare+Choice, as it was then known, in order to ensure that payments appropriately take into account the health status of plan enrollees. Numerous analysts had found that the previous, inadequate risk adjustment system was allowing plans that were enrolling beneficiaries who were healthier on average than those in original Medicare and thus less costly to treat to receive significant overpayments. CMS implemented the current risk adjustment system in 2004, though plans were fully or partially shielded from any effect on their payments through 2010.

In the Deficit Reduction Act of 2006, Congress explicitly required CMS to assure that any differences in coding patterns between MA and FFS are reflected in the risk scores for purposes of risk adjustment for 2008 through 2010. The policy in the Advance Notice finally fulfills that responsibility, albeit only for 2010.

Providers in FFS Medicare have been subject to adjustments due to changes in coding patterns for many years. CMS has proposed or implemented across-the-board downward adjustments for hospitals, home health agencies, skilled nursing facilities, and others in past years to account for historical or projected coding changes that are not attributable to a change in case mix. MA plans should not be exempt from such adjustments.

Because the problems in plan upcoding have been so significant and widespread, it is appropriate that CMS make an adjustment that applies to all MA plans. While the policy will not, and cannot, modify the payments to each plan in exact proportion to its level of upcoding, the perfect must not be the enemy of the good. As CMS develops the risk adjustment system, we encourage it to consider options for making differential adjustments based on the magnitude of each individual plan's upcoding. CMS should not wait for such arrangements to be developed to implement its proposal in the Advance Notice. This approach is also consistent with that used for FFS providers, as described above.

The proposal described in the Advance Notice is a sound first step, but it does not solve the problem entirely. CMS proposes adjusting for three years of measured upcoding by plans. The Deficit Reduction Act requires CMS to adjust for all differences in coding patterns, so CMS should adjust for all measured and projected differences, including those attributable to the excluded period for 2004-2007. We also encourage CMS to continue its efforts to collect additional data from MA plans, including data relating to all medical encounters between beneficiaries and providers, to improve the accuracy of the risk adjustment system, and to measure the effectiveness and integrity of MA plan benefits.

We appreciate the Administration's efforts to improve the accuracy and fairness of MA payments, and we look forward to working with you as we repair this nation's health care system.

Sincerely,

Henry A. Waxman
Chairman
House Energy and Commerce Committee

Charles B. Rangel
Chairman
House Ways and Means Committee

John D. Dingell
Chairman Emeritus
House Energy and Commerce Committee

Frank Pallone, Jr.
Chairman
Subcommittee on Health
House Energy and Commerce Committee

Pete Stark
Chairman
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